MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

# REQUEST FOR AUTHORIZATION OF PRIVATE ROOM SUPPLEMENTAL PAYMENT FOR NURSING FACILITY

This is my written request for authorization of supplemental payment for a single room for:

Name of Beneficiary/Resident: _____

Medicaid ID Number: _____

Facility Name: _____

Facility Address: _____

_____

Facility Telephone Number: **(  )  -** _____

The basis for this request is:

☐ I believe a single room is medically necessary. (If medically necessary, the Medicaid daily rate already pays for a single room.)

☐ I believe a single room is not medically necessary, but is needed for the following reason(s):

_____

_____

I understand that I must accept responsibility for paying the difference between the facility's two-person room and single room rates that are listed below. I will pay any difference in the rates that may change over time, as long as a single room is needed.

Two-person room rate: $_____ /per day

Single room rate: $_____ /per day

Printed Name of Requestor: _____

Address: _____

_____

Telephone Number: **(  )  -** _____

Relationship to Beneficiary/Resident: _____

_____ _____

Signature of Requestor Date

**MAIL TO:** Long Term Care Services
Michigan Department of Community Health
P.O. Box 30479
Lansing, MI 48909-7979

**FAX TO:** (517) 241-8995

**NOTE:** If no response is received within 10 working days, contact (517) 241-4293.